

# Prospects for Episode-Based Payment

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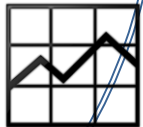


# Overview



The potential

Our experience



Its prospects and state options



# Conceptual appeal

- “Natural history” of medical care
- Framework for care integration
- Focus on value in service lines
- “Technical” risk



# Promising evidence base from older programs



## **58 studies reviewed**

4 review articles of the Medicare Inpatient Prospective Payment System



## **Decreases in spending and utilization**

Consistent, if weak, evidence



## **Doesn't adversely impact quality**

Small, inconsistent effects



# Newer programs are different

- Bigger bundles
  - Multiple providers and provider types
  - Longer time periods
  - Higher costs
- Quality measurement
- Policy environment



# Retrospective vs. Prospective

- Retrospective: fee-for-service payments
  - Incentive for providers is to conduct as many services as possible
- Prospective: fixed fee per group of services (an episode of care)
  - Incentive is to reduce services to maximize revenue
- Retrospective (2): Setting target fee per group of services based on historical data
  - Providers paid fee-for-service and then compare their actual spending to target fee for episode
  - If under the target, the provider shares in the savings



# How prevalent is episode payment?

- 0.1 percent of payments<sup>1</sup>
- 9 private payers identified<sup>2</sup>
- Large public payers
  - Medicare
  - Arkansas, Tennessee



# Evaluations of 2 private sector pilots were negative

**Bundled Payment Fails To Gain  
A Foothold In California: The  
Experience Of The IHA Bundled  
Payment Demonstration**

**The PROMETHEUS Bundled  
Payment Experiment: Slow Start  
Shows Problems In Implementing  
New Payment Models**



# IHA Bundled Payment Demonstration

- 2010-2013
- Target: under-65 commercial population in California
- Participants included six of California's largest health plans, eight hospitals, and an independent practice association



# Thorough implementation process

- Consensus-oriented planning and implementation process
- Data analytics
- Model contract provisions



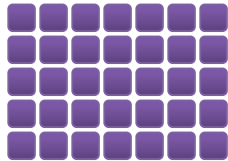
## Signed episode payment contracts:



3/6 health plans



2/8 hospitals



35 cases performed in 3 years



“It definitely went longer than any of us thought... when you peel back the onion, you find things that complicate this, and it can take a long time.

When these things take a long time people tend to lose interest, and start to think it's never going to happen.”

*(Physician organization)*



“I think everyone was interested in the concept but when it got to the nitty-gritty, the dollars, it became clear they had no desire to go forward.

The hospitals that participated were more there to protect what they had. They weren't looking for the cost savings like we were looking for them.”

(Health Plan)



# Other barriers

- Lack of technical infrastructure for claims processing and claims payment
- Time delays and lack of certainty surrounding state regulatory decision-making



# Silver lining

- Participants valued experience despite lack of implementation
- Improved understanding of performance and capabilities



# Bundled Payment for Care Improvement (BPCI)

- January 2013- December 2016
- Retrospective payments (except Model 4)
- Voluntary participation
- Providers choose from 48 episodes of care
  - Most common choice was joint replacement



# BPCI Phase 2 Participants



Source: Centers for Medicare & Medicaid Services



# BPCI Models

- Four Models (Participants in Phase 2)
  - Model 1: Retrospective Acute Care Hospital Stay Only (0)
  - Model 2: Retrospective Acute Care Hospital Stay plus Post-Acute Care (741)
  - Model 3: Retrospective Post-Acute Care Only (1353)
  - Model 4: Acute Care Hospital Only (10)
- Model 2 and 3 can choose 30, 60, or 90-day episodes



# Retrospective Payment

- Target price based on 2009-2012 data on episode spending
- Target based on each participant's baseline spending with 2-3% discount
- Trended forward for each participation year



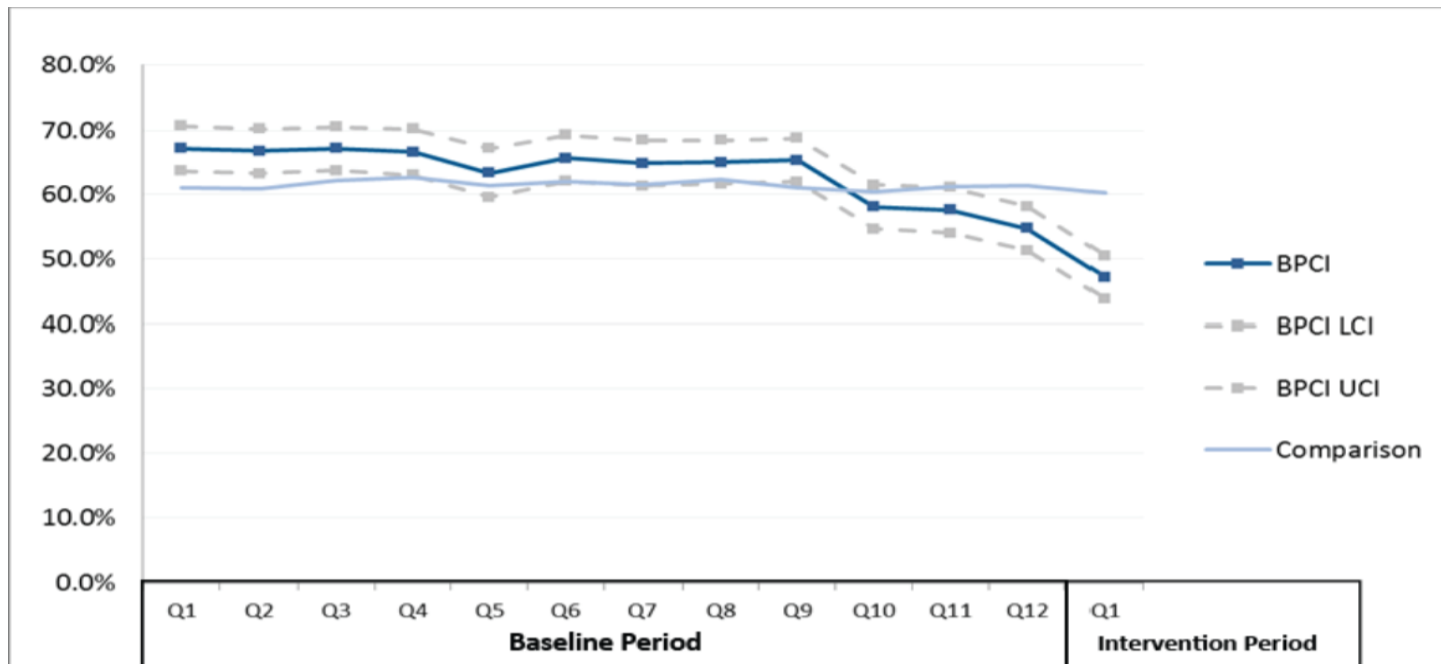
# Limited Evaluation Evidence Available

- Quantitative analysis only for first quarter of Phase 2 (Oct-Dec 2013) and 3-year baseline
- Low sample sizes
  - Model 2: 9 participants, 1713 episodes
  - Model 3: 9 participants, 876 episodes
  - Number of Awardees and Episode Initiators (EIs) greatly increased in 2014, but not yet evaluated quantitatively
- Interpret results with caution because of **small sample size** and **short time-frames**



# Year 1 Evaluation Results: Model 2

Risk-Adjusted Percentage of PAC Users Discharged to Institutional PAC After Anchor Hospitalization, Model 2 Surgical Orthopedic Excluding Spine Episodes



Source: Dummit L, Marrugo G, Marshall J, et al. CMS Bundled Payments for Care Improvement (BPCI) Initiative Models 2-4: Year 1 Evaluation & Monitoring Annual Report. Falls Church, VA: The Lewin Group; 2015.



# Year 1 Evaluation Results: Model 2

- Orthopedic episode spending decreased more for BPCI patients vs. controls
- No significant change in institutional post-acute care days among patients using post-acute care
- Hospital length of stay decreased more for BPCI patients vs. controls
- Increase in ED use during episode for BPCI patients (vs. slight decrease in controls)



# Year 1 Evaluation Results: Model 3

- No significant difference in trends in post-acute care days or readmissions
- Home health spending increased more for BPCI patients
- BPCI patients had lower costs, utilization than non-BPCI patients at baseline

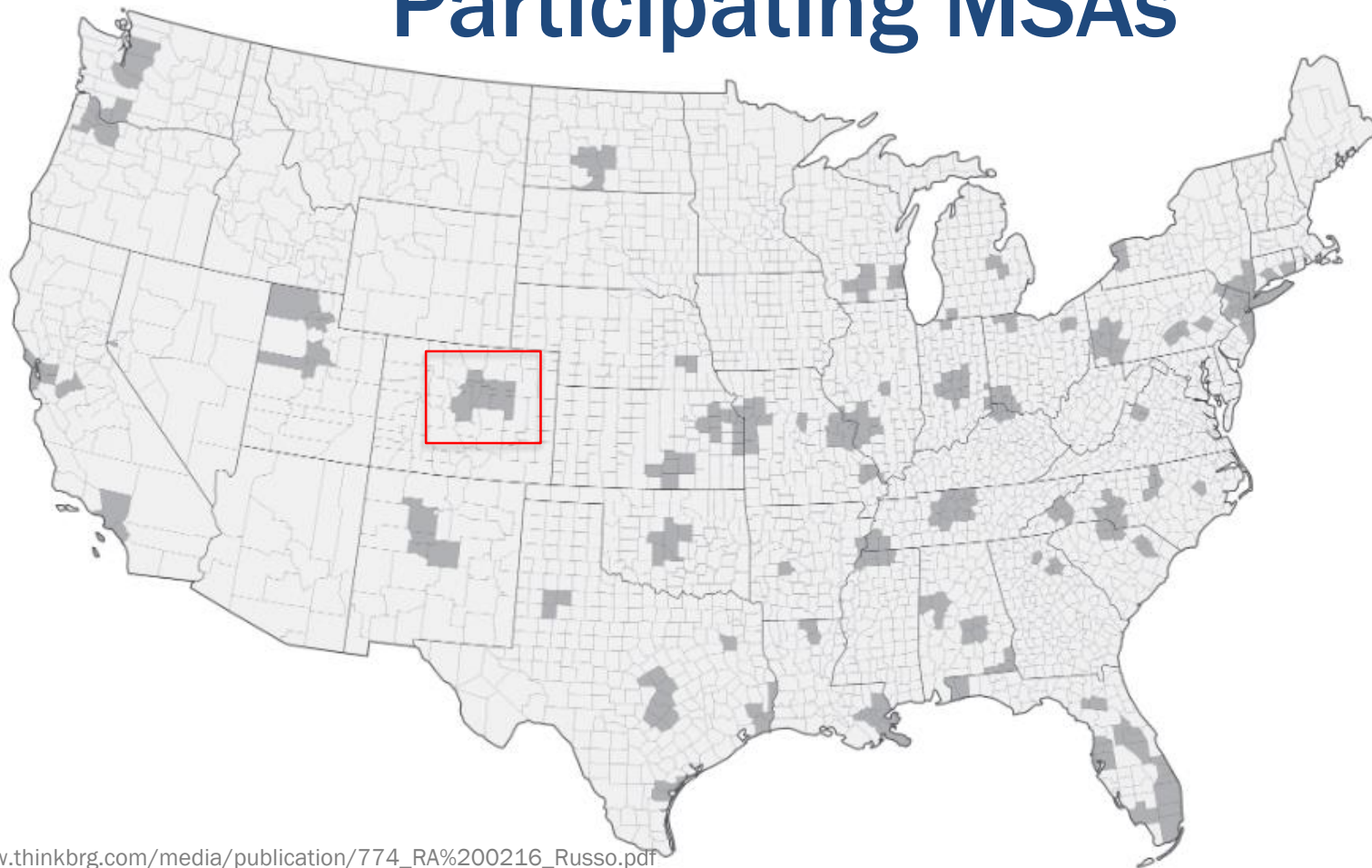


# Comprehensive Care for Joint Replacement (CJR)

- 2016-2020
- Target: Medicare joint replacement patients in 67 MSAs
- Required of all hospitals within the 67 MSAs

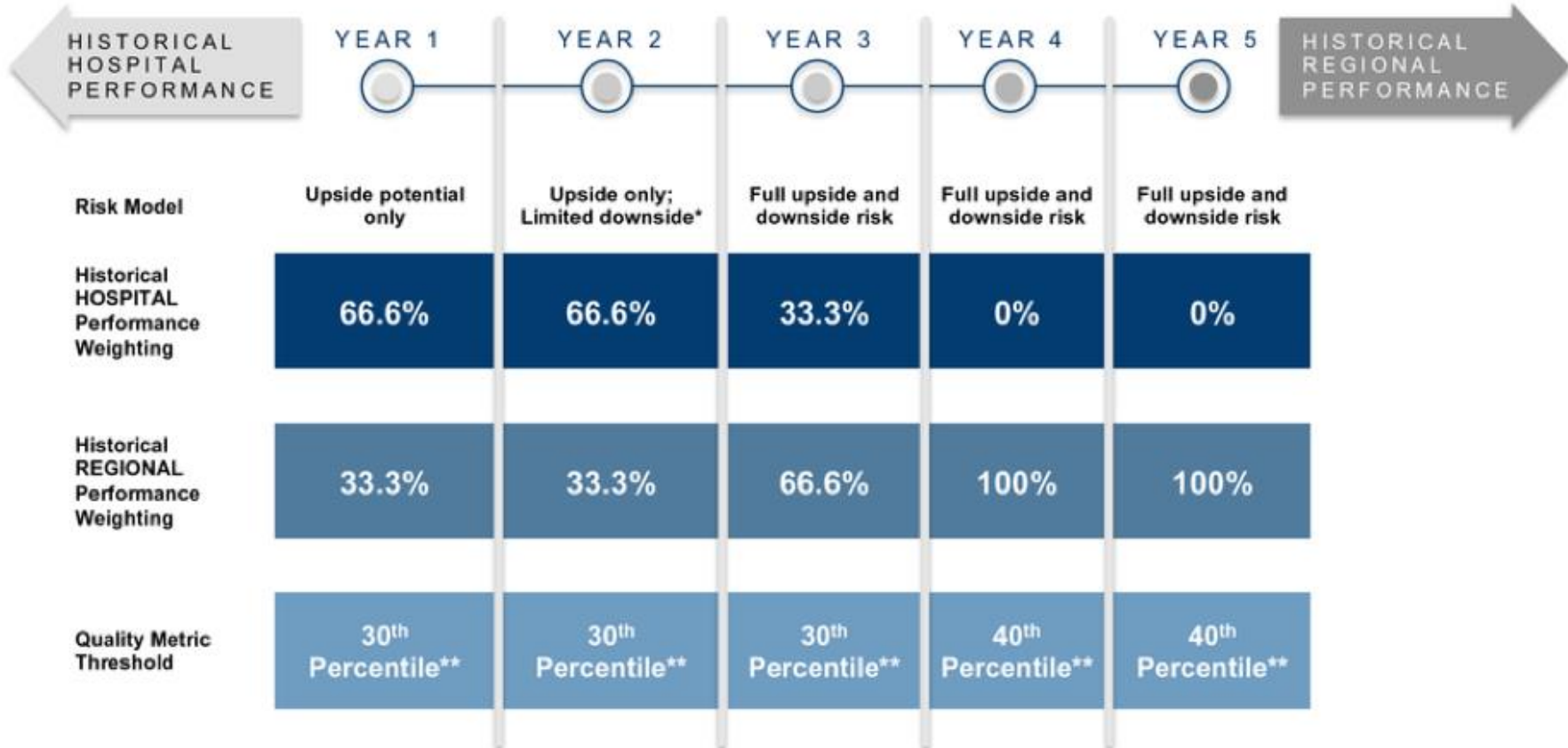


# Participating MSAs



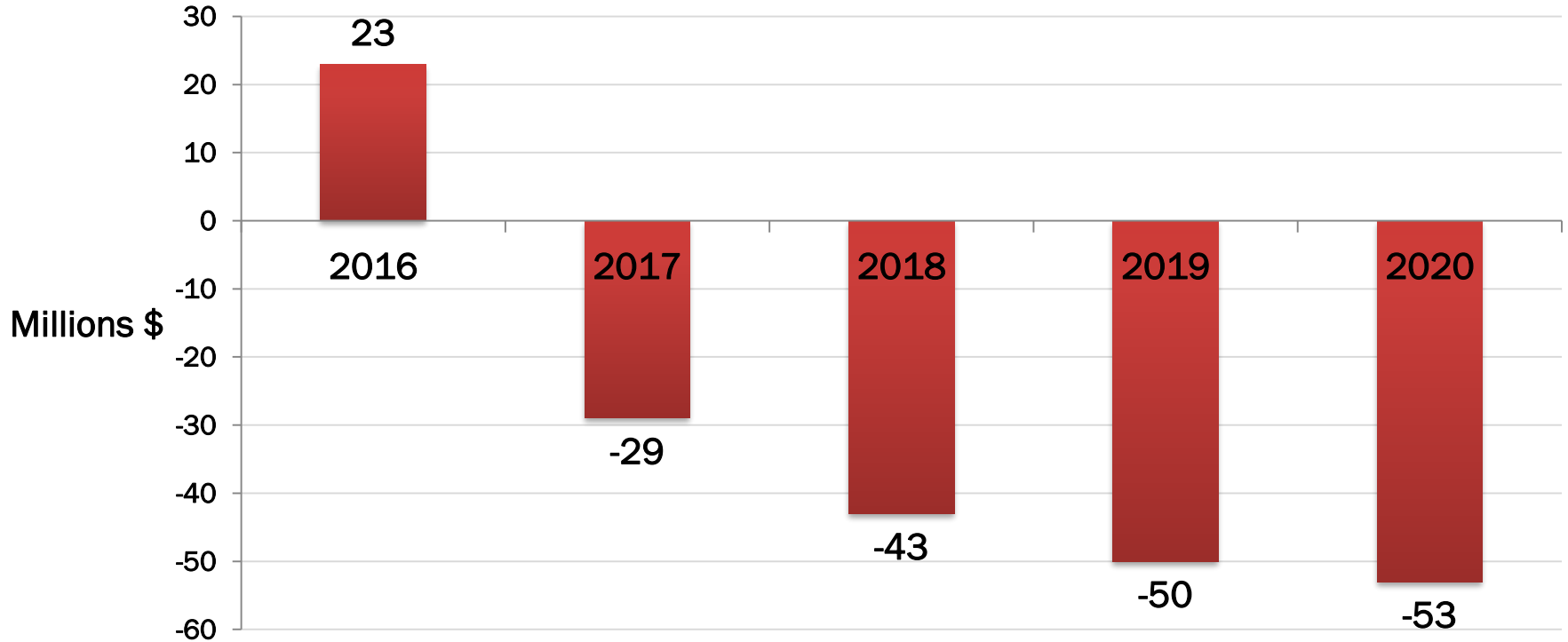


# Payment Methodology





# CMS Projected Budget Impact





# BPCI Model 2 vs. CCJR

Category	BPCI Model 2	CCJR
Episode Services Included	Inpatient stay, post acute care, and all related services during the episode	Same
Episode Trigger	Admission in selected DRG	Same
Number of Episode Types	Up to 48 episodes	2 episodes
Episode Duration	30, 60, or 90 days	90 days
Prices	2-3% discount for 30 and 60 day episodes, 2% discount for 90 day episodes; based on providers' historical payments	2% discount for all episodes (1.7% for additional data delivery to CMS); based on provider and regional averages
Participation	Voluntary	Mandatory in selected regions
Episode initiators	Hospitals, physician groups, or post-acute care providers	Hospitals only



# AMA, AHA Critiques of CJR Proposed Rule

- Lack of flexibility needed to innovate in care redesign
  - Existing payment rules
  - Organizational arrangements
- Inadequate risk adjustment
- Hospitals assume too much risk for post-acute care
- No clear mechanism to join CJR if not previously selected



# CMS Oncology Care Model

- CMS initiative to start Spring 2016
  - Voluntary enrollment in program (applications closed)
- Retrospective payment scheme
  - \$160 PMPM payment for enhanced services in care management and performance-based payments
  - Benchmarks based on historical data, risk-adjustment, and trends. Discounts applied afterwards
- Contingent on round the clock outpatient services to reduce hospitalization (expected to be greatest source of savings)
- Episode defined as 6 months after the first dose of chemotherapy (4 month extension if qualified)



# Arkansas Health Care Payment Improvement Initiative

- Multipayer program
  - State Medicaid program, Arkansas Blue Cross and Blue Shield (AR BCBS) and QualChoice of Arkansas (QCA) involved (on an episode-by-episode basis)
- Retrospective payments based on episode payments and quality relative to peers
- Target price set by each payer based on historical Arkansas payments



# Principle Accountable Providers (PAP)

- Responsible for coordinating the care of patient
  - PAPs are the entities sharing the financial risk
- PAP is usually a clinician
  - Upper respiratory infection: trigger is diagnosis of URI, diagnosing physician is PAP
  - Perinatal: trigger is delivery of a live infant, delivery provider is PAP
  - THKR: trigger is procedure, orthopedic surgeon is PAP
  - CHF: trigger is hospitalization, index hospital for admission is PAP
  - ADHD: trigger is diagnosis, primary care or mental health provider is PAP



# Issues with Preliminary Results

- State tracking results, not an independent evaluation
- Not all episodes were adopted by all payers
- Many episodes had too few cases to assess
- Tracking focuses on quality metrics, not costs



# Arkansas Year 1 Results

- **Perinatal:** Medicaid C-Section rate improved from 38.6 to 33.8%, average length of inpatient stay increased from 2.2 to 2.6 days, and the rate increased from 38.0 to 38.5%
- **TJR:** wound infection rate decreased from 8.5 to 1.1 per 1,000 performances per year, 30-day all-cause readmission rate improved from 2.55 to 2.09%, 90-day post-op complication rate improved from 3.4 to 2.63%
- **URI:** prescription rates for non-specified URI decreased from 44.6 to 37.1%, more PAPs with commendable and acceptable range than unacceptable range during performance year.
- **CHF:** In Medicaid, decrease in 14-day observation rate from 42.67 to 40.09%. In AR BCBS 30 day all-cause readmission worsened from 10.42 to 13.51%



# Will Episode-Based Payment Achieve Its Promise?

- Numerous pilots are under way; preliminary results only
- Relationships with other payment models (e.g., ACOs) not clearly defined yet
- Conceptually appealing but difficult to implement



# Options for States

- Arkansas-like multipayer model
- Piggyback on Medicare models in state insurance programs



